DELTA DENTAL® Claim Form

Delta Dental Plan of Colorado

Customer Service: 1-800-489-7168

RETURN TO:
Delta Dental Plan of Colorado
P.O. Box 173803
Denver, CO 80217-3803

1. PATIENT NAME - PLEASE PRINT — FIRST | LAST

2. RELATIONSHIP TO EMPLOYEE — SELF ☐ SPOUSE ☐ CHILD ☐

3. SEX — M ☐ F ☐

4. PATIENT BIRTHDATE — MO | DAY | YR

5. IF FULL TIME STUDENT, CITY, STATE, SCHOOL NAME

6. EMPLOYEE NAME — FIRST | LAST

7. EMPLOYEE SOCIAL SECURITY NUMBER — ___ - ___ - ____

8. EMPLOYEE BIRTHDATE — MO | DAY | YR

9. EMPLOYEE MAILING ADDRESS

CITY | STATE | ZIP

10. NAME OF EMPLOYER

State of Colorado

11. GROUP NUMBERS (select one only)

☐ **BASIC Plan - 006784**

☐ **BASIC PLUS Plan - 006785**

12. IS PATIENT COVERED BY ANOTHER PLAN? NO ☐ YES ☐

13. IF YES, ATTACH EXPLANATION OF BENEFITS (EOB) NO ☐ YES ☐

14. ENTER OTHER FAMILY MEMBER EMPLOYED WITH BENEFIT COVERAGE.
OTHER NAME | RELATIONSHIP | SOC. SEC. NO. | BIRTHDATE MO DAY YR | OTHER DENTAL PLAN NAME

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL HISTORY, CONDITION OR TREATMENT, AS NEEDED TO DETERMINE BENEFITS RELATED TO THE DENTAL WORK FOR WHICH THIS CLAIM IS MADE. I UNDERSTAND AND AGREE WITH THE TREATMENT RECOMMENDED AND SUBMITTED ON THIS FORM. I CERTIFY THAT THE INFORMATION IN BLOCKS 1 THROUGH 15 IS TRUE AND CORRECT.

15. SIGNATURE OF PATIENT
(or parent or guardian) _____ DATE _____

16. DENTIST NAME

17. MALING ADDRESS

CITY | STATE | ZIP

18. DENTIST SOC. SEC. NO. OR TAX ID NO.

19. DENTIST LICENSE NO. STATE

20. DENTIST PHONE NO. ( )

21. PREDETERMINATION NO ☐ YES ☐

22. PAR N PAR

23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY?

24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO ☐ YES ☐ IF YES, ENTER BRIEF DESCRIPTION AND DATES.

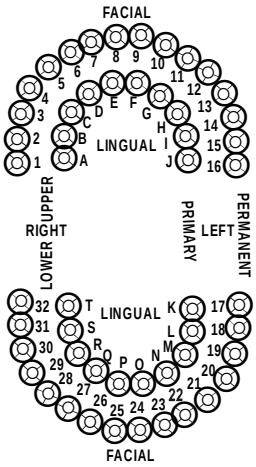
25. IS TREATMENT RESULT OF AUTO ACCIDENT? NO ☐ YES ☐

26. OTHER ACCIDENT? NO ☐ YES ☐

27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO ☐ YES ☐ IF NO, REASON FOR REPLACEMENT? DATE OF PRIOR REPLACEMENT?

28. IS TREATMENT FOR ORTHODONTICS? NO ☐ YES ☐ IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED. MOS. TREATMENT REMAINING.

IDENTIFY MISSING TEETH WITH "X"



30. REMARKS FOR UNUSUAL SERVICES

29. EXAMINATION AND TREATMENT PLAN - USE CHARTING SYSTEM SHOWN

TOOTH OR QUAD	SURFACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	DENTIST FEE	FOR DELTA USE ONLY
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

31. DENTIST'S SIGNATURE _____ DATE _____

TOTAL FEE CHARGED

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental Plan of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete, or misleading facts to Delta participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

ATTENDING DENTIST'S STATEMENT

COPY AS NEEDED